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Oak Park Pediatrics Lactation Consult Intake Form

Name of mom: _____ Name of baby: _____

Your OBGyn/Midwife: _____ _____
Name Phone number

Why are you here today? What can the doctor help with?

What are your breastfeeding goals? Short term, long term? How long do you hope to breastfeed?

What are your previous breastfeeding experiences?

What is your occupation? _____

Length of maternity leave? _____

About this pregnancy and baby:

What number pregnancy is this for you? _____

What number baby is this for you? _____

How many weeks gestation was the birth? _____

Vaginal or C-section? _____

Any complications during the pregnancy? _____

Did you experience breast changes during pregnancy (increased size, firmness, discharge)?
____Yes ____ No If yes, what changes? _____

About this delivery:

Any complications during the delivery or afterwards (for you or baby)? _____

Feeding Details:

How many times do you breastfeed at the breast each day? _____

_____ minutes On which sides? (circle one): Left Right both alternating

Are you pumping? (circle one) Yes No

If yes, how many times/day: _____

_____ minutes (circle one) [ ] In addition to or [ ] Instead of breastfeeding

Approximately how much do you pump at each pump session?

Left breast: _____ oz or mL (circle one)

Right breast: _____ oz or mL (circle one)

What kind of pump do you have? _____

How much milk does your baby get by bottle/soft feeder/other feeding device per feeding? _____ oz or mL (circle one) How many times/day? _____

Does your baby take a pacifier (circle one)? Yes No

Elimination

About how many wet diapers does your baby have each day? _____

About how many poops does your baby have each day? _____

What is the color/consistency of your baby's poop? _____

Medications taken during pregnancy (please list):

Current Medications (please list below):

Mom **Baby**

Do YOU have a history of any of the following, current or past? (please check any that apply)

	PCOS		Postpartum Depression		Oversupply of milk
	Fertility Problems		Eating Disorder		Not enough milk
	Ovarian Cysts		Dietary Restrictions (meat, dairy)		Breast Surgery
	Anemia		Diabetes		Breast Biopsy
	Thyroid problems		Inverted Nipples		Breast Reduction
	Depression		Flat Nipples		Breast Augmentation
	Anxiety		Sore Nipples		Other medical problems?

Please give details of any positive responses above:

Do YOU have any of the following currently: (check any that apply)

	Breast pain or tenderness		Fevers/chills		Anxiety/depression
	Nipple pain or tenderness		Body aches		Excessive fatigue (debilitating)
	Cracked nipples		Breast redness		Excessive vaginal bleeding
	Breast engorgement		Plugged ducts/breast mass		

If you are having breast pain, please circle any of the following that apply:
(Please specify which breast, if only one)

	Nipple pain only		Burning or shooting pain		Deep aching pain
	Deep breast pain		Pain worse with latch		Pain better while nursing (after initial latch)
	Pain worse between feedings				

Does YOUR BABY have any of the following? (check all that apply)

	Difficulty latching		Falling asleep easily during feedings		Noisy eating
	Excessive spit-up		Short of breath while feeding		Not waking up on his/her own for feedings